



## **Report of the Regional Consultation on Responding to the Target Free Approach**

**Held in Pune on January 31 & February 1, 1997**

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## *Centre for Enquiry into Health and Allied Themes (CEHAT)*

The Centre for Enquiry into Health and Allied Themes, CEHAT is a non-profit research collective/organisation set up with the primary objective of conducting research on topics of relevance to the health and well-being of the disadvantaged and the poor. It functions as an interface between progressive and pro-people movements and academic expertise.

CEHAT represents the outcome of a long process of debate and discussions on the increasing need to create a structure which could in a disciplined manner enquire into the many troubling questions thrown up by and within people's movements and provide a data base and well-substantiated answers. Some of these topics may involve quantification and estimation, for instance, the volume of resources wasted on irrational drugs. Others may extend, deepen and influence currently applied norms of medico-legal jurisprudence such as research on domestic violence, torture or rape. Some may impinge on medical ethics and may raise further questions as in explorations of the responsibility of the medical community towards patients. Studies and surveys on women's experience with abortion or contraception or their perceptions of health and illness will seek to inform mainstream analyses, while those on psycho-social trauma of populations forcibly displaced or the concept of social wage and what it implies, will reveal what is hidden even as they influence the process of change towards a more sustainable and equitable society.

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On principle, CEHAT does not regard society either as a ground for experimentation or as unexplored terrain for data-gathering for intellectual exercises. Given this, all CEHAT's projects endeavour to create space for the participation of people in the study without compromising on academic rigour. All CEHAT's projects include ethics committees and are committed to return the results of research to participants and respondents, in an appropriate manner.

### **OBJECTIVES**

1. Conduct research and action-research on topics of importance or interest from the point of view of people's movements in the country.
2. To interact with progressive movements, in related areas, such as women's groups, trade unions and campaigns or organisations involved in human rights issues and provide research inputs.
3. To identify research priorities in health at local, national or international levels, the findings of which will directly or indirectly benefit oppressed, marginalised or silent sections in society.

The emphasis in CEHAT is on a democratic and participatory mode of decision-making. An external social audit group periodically evaluates CEHAT's performance in collective management and the relevance of research directions of the centre.

At present CEHAT functions with a corpus fund raised to ensure a degree of financial stability for staff with a just pay on social environment.

CEHAT is a research active organisation presently coordinates the activities of Dr. Mankad, Ms. Manisha Gupta, Dr. Patel. The trustees have expertise in economics, sociology, journalism and full-time research in health and

re, a corpus fund will be raised. It will aim to provide its staff with a conducive work environment.

Dr. Amar Jesani (who is currently engaged in research in the fields of medicine, epidemiology and public health), Dr. Dhruv Duggal and Dr. Vibhuti Patel are currently engaged in research in the fields of medicine, epidemiology and public health.

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# **REPORT OF THE REGIONAL CONSULTATION ON RESPONDING TO THE TARGET-FREE APPROACH**

## **ACKNOWLEDGEMENTS**

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**January 31 & February 1, 1997**

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# REPORT OF THE REGIONAL CONSULTATION ON RESPONDING TO THE TARGETED HIV ATTACK

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January 31 to February 1, 1997

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## PREFACE

Women's health has for too long been seen within the narrow confines of maternity. The family on the one hand pushes women to produce sons and the government health services on the other hand coerce women to limit the size of the family through provider controlled and long acting (or terminal) methods of contraception. Maternity is over-valued in Indian society to the extent that childless women are stigmatised, deserted and are rendered more vulnerable to violence and bigamy on the husband's part. The State, with an overt bias towards population control treats fertility as a disease with poor women as its carriers.

No wonder then, that the public health services reflect these biases too. In the first place, the public health infrastructure is poor, the personnel inadequately trained, resources including drugs and equipment rarely available - even at primary health centres. Poor developmental infrastructure such as lack of pliable roads and transport services make these (often ill-placed) services even more inaccessible. Linking vital services such as abortion or childbirth with sterilisation or contraceptives adds insult to injury for most poor women. The private sector, with its expensive and often irrational (or even harmful) treatment then becomes the 'choice' for most people who incur vast amounts of debt for the much needed curative services.

In this light, the Indian government's attempt towards humanising the family planning campaign by making it target-free is a welcome step. It is certainly a better thing to do than coercing people into permanent methods of contraception (remember the Emergency?). For over two decades now the women's movement as well as health activists have demanded that targets be removed from the family planning campaign and in a sense, this official move will certainly give some respite to community based health workers, especially the over-worked Auxiliary Nurse Midwife (ANM) as well as to women in the reproductive age group.

Having said this much, one needs to examine the reasons and the strategies of the government vis-a-vis the target free approach. With women becoming vocal over the years through being organized by women's groups and Non-Governmental Organisations (NGOs) it is now hardly possible to launch an anti-woman campaign without creating an uproar. To supplant it, an 'unmet need' of contraception has been identified among Indian women and the launching of a soft approach in contraception is expected to work better at this stage than coercion ever will. The basic fact that population policies (whether pro or anti-natalist) are in themselves eugenic and de-humanising or that women have many other unmet needs as well, (such as poor access to legal rights, to housing or decent jobs, for example) is not the main political debate, now. Giving the population policy a human face by linking it to development is the current slogan.

Whatever the reason be, the fact that reproductive health needs of women are being articulated in government and NGO quarters is in itself a positive sign. The role of progressive groups would be to create pressure for expanding the existing policy on reproductive and child health into a much broader policy on women and health that encompasses other vital and hitherto neglected areas such as work and health, emotional health, violence, abuse, medico-legal jurisprudence, impoverisation and so on. A demand for answerability within the public sector and regulation of the private sector so as to make health care universally available to every one would have to be raised once more.







Rather than accept 'packages' of health care, it would be worthwhile to press for a comprehensive public health policy that provides good quality health care for all people, including women, irrespective of their capacity to pay. In real terms it would mean an overhauling and reinforcement of the existing health care infrastructure and making it accessible in physical and financial terms for all Indian people. Gender sensitivity within such a policy which takes serious cognizance of the special needs and socio-economic position of women is a must.

With a view to debate and clarify some of the above issues, CEHAT, being a founder member of the 'Health Watch' network, decided (in collaboration with 'Health Watch') to organise a consultation with health activists, NGO representatives and Government officials from Maharashtra-Goa region for two days in Pune. Though the participants came from varying backgrounds and experiences, they agreed on certain basic issues - namely that the target free approach as defined in the government manuals was inadequate and that reproductive health services would not be of much value unless they were contextualised within the broader framework of people's right to basic health care in India, of which women's health concerns would be an integral part.

We have great pleasure in circulating this report to all of you who have been concerned with issues related to women and health. The dialogue that started in this consultation needs to be strengthened in a way that the target-free approach is certainly not abandoned by the state in a haste, and that the myopic definition of 'women and health' evolves beyond the understanding of maternity and fertility.

Ms. Manisha Gupte.

Member, Governing Board,  
CEHAT.







## Introduction

Participants at the regional meeting of health workers, researchers, and activists from Maharashtra and Goa deliberated upon the merits and implications of the Target Free Approach (TFA) to Reproductive and Child Health (RCH) put in place by the Ministry of Health and Family Welfare since April 1996, at a two-day meeting which concluded on February 1, 1997. This consultation was jointly organised by the Centre for Enquiry into Health and Allied Themes (CEHAT) and Health Watch.

It was felt that the new 'target--free' approach to reproductive and child health care marks a much needed and long awaited first step towards a complete revamping of health policy. This approach tries to move away from counting sterilisations as an indicator of reproductive health, to providing real reproductive health care through the public health services.

However, there was a strong consensus that the new policy as outlined in a manual to be used by public health functionaries at various levels falls far short of taking care of real health care needs of people, and women in particular. It continues to think of reproductive health and 'family planning' synonymously, while virtually ignoring most rational reproductive health indicators. It makes no efforts to offer good quality curative care. As a result, while abandoning the target approach is appreciated, it is highly unlikely to make any real difference in this essential area of health in the present form.

It would be far more rational to integrate reproductive and child health into a comprehensive package for delivering quality basic health care to the people. Such a health package should be available to all, independent of their ability to pay and must take into account the socio-economic conditions of communities while delivering care. Given women's poor access to health care, there might still be the need to have a special women's health programme within such a package, but it should be considerably more comprehensive than simply taking care of their reproductive health in the 'family planning' mode.

The participants also came up with criticisms and suggestions for improvements in the development of human resources, the training and other needs of health workers, public health infrastructure, the quality of the care it delivers, and ways to evaluate its efficiency and effectiveness.

All these deliberations and recommendations are reported in detail in the following sections.







## Major Topics

### Reproductive and Child Health approach and health care

The strongest criticism of the RCH programme was that a separate and stand--alone reproductive and child health package was the wrong policy to follow. There must be a basic package of comprehensive health care available to all, which covers not population control driven targets, but addresses the basic health care needs, such as curative care for common diseases, dental care, mental health, occupational health, for both men and women. Such care must be provided with an acknowledgment and understanding that social and cultural factors affecting men and women are different, and therefore there must be gender sensitivity in the care as well. In this regard, many times the view was expressed that a special programme for women's health needs still remains necessary since they have been excluded from such care for far too long, having had only their reproductive capacity under the lens. In fact, even within the purview of reproductive health mostly women have been targeted, only during their child-bearing years, and only from the viewpoint of population control. This must change. It must be recognised that women have reproductive health care needs that fall outside the limits of family planning and child care, and as long as these are not treated by a routinely accessible and efficient system, there is little chance of having a healthy population, small or large. Right to basic health care must be made fundamental and it must be made available to all irrespective of people's ability to pay.

A large number of suggestions were made to concretise this view of a comprehensive health policy. A list of services which should be covered in such a programme was as follows:

- . general practitioner/family physician services for personal health care,
- . first referral hospital care and basic specialist services (paediatrics, gynaecology and obstetrics, general medicine and surgery, occupational and mental health, dental services and ophthalmology, special diagnostics),
- . immunisation services for vaccine preventable diseases,
- . maternity services for safe pregnancy, abortion, delivery and post-natal care,
- . pharmaceutical services, including laboratory services, surveillance and control of major diseases with the aid of continuous surveys, information management and public health measures,
- . contraceptive services,
- . health education and information,
- . ambulance services.

There was discussion of the referral system. It was pointed out that with the rapid growth of the private sector in both rural and urban areas, coupled with insufficient public services, most first contact care was handled by this sector. An estimated 1.2 million qualified and as many unqualified doctors were involved. This is an important area of consideration for the state in designing the comprehensive health system. However, the integration of the private practitioner into a health care package must be well regulated under the single umbrella of a national health authority. There should be rationalisation of resource distribution, an efficient referral system and insurance plans available.





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In a study on factors affecting health seeking and utilisation of curative care, it was presented that even in rural areas, private care was preferred at first contact. This was based on a perceived notion that the quality of this care was better than that in the Primary Health Centres (PHCs). Also, socially and economically dominant groups used private care, while deprived and marginalised communities used the PHCs, only because they could not afford private care. At the PHC level it was found that the ANMs were so burdened with family planning work that they hardly provided any curative care, leaving the underprivileged communities with no choices for such services. It was felt that the now defunct Community Health Volunteer scheme should be reinstated to un-burden the ANM and rationalise the contact between communities and the PHC that serves them.

Regarding finances, it was pointed out that in the existing system of health care, the distribution of resources between urban and rural was rather skewed. 15 percent of the budget of the health ministry goes towards family planning, and 40 percent towards hospitals and medical care. However, 80 percent of the 15 is spent in rural areas while 85 percent of the 40 in urban. An estimate based on current use and an average morbidity rate of 2 percent suggests that Rs.500--600 per capita needs to be spent in order to give quality basic health care. This is about four times the present spending. It was pointed out that utilisation of such a universal care package will be high initially, rising geometrically, and then fall and level off as health needs reduce to optimal levels.

In order to do a needs assessment study for planning resources, it was pointed out that much of the first contact care in the private sector was completely undocumented. In rural areas where people were using PHCs, the driving agenda of population control and family planning under which the public health workers operated meant that there was no information about general health care needs from this area either. Such studies need to be done in order to identify priority health care areas specific to communities. NGOs should contribute by taking up such studies.

### **Health care for women**

This topic pervaded all the discussions. This section gives an overview of the breadth of concerns studied and expressed. Details of recommendations for improvements within the target free approach and the RCH programme are given in subsequent sections. As mentioned in the previous section, there was a strong feeling among many participants that even within a structure such as a comprehensive basic health package, there was a necessity for a women's health programme. Such a programme must be aimed at expanding the health services available to women a great deal. There was broad consensus on the details of what such services should include. It was felt that the planned RCH package must incorporate these to make it effective in the long term.





It was agreed that instead of devising family planning policies, the need of the day was to empower women to take charge of their basic health care, with efficient and accessible support from the state system. If this was done, family planning would become a matter of rational, but personal choices. Lowering of birth rates would then follow as the natural consequence.

Given the stated policy of the ministry to abandon population control targets, there was a very strong need to put into place assessments of women's reproductive health indicators based on a broad picture of the social, economic, and health environs of women. That such a picture can be very complex was stressed in several presentations.

A study of women as disadvantaged in access to health care, with specific reference to abortion presented the view that the woman suffers from her ability to bear children in both spheres; the family and the state. The state sees her fertility as something that must be regulated, and she gets selective services and counseling according to that aim. So she never has the freedom of informed choice in planning her reproductive life. However, maternal mortality is very high and flies in the face of the stated policy. Even within the family, her ability to bear children, and sons in specific, only gives her security of sorts without ever giving her real control over when and how she wants to have them, and she remains dispensable.

If she is infertile for some reason, she becomes virtually invisible to the state, but suffers greatly at the hands of family and community, and is proven to be dispensable.

With so much emphasis being placed on their fertility alone, women are often seen to be unable to seek care for gynaecological illnesses that are not directly related to pregnancy. This is even more understandable since the public health workers at PHCs are known to be callous, insensitive, and often intimidating. This is especially true of abortion services. The quality of care indicator changes according to the social and economic status of the women. Unmarried women have even less power of bargaining and must seek such abortions in the expensive private sector. There is also the frequent demand for the husband's signature. This is not included in the Medical Termination of Pregnancy (MTP) Act. Its an interpretation governed by the existing social values, which makes it even more difficult for women to get such services on demand. Further, women are pushed to accept provider controlled and invasive contraception following an MTP. This further reduces women's access to safe abortions.

There are absolutely no services available for occupational health problems, domestic abuse alleviation and mental health. Older women are deemed to be permanently fit, and no counseling is done about menopause and its side effects.

Given such complex social and economic constraints on the care of the reproductive health of women, there were a number of issues which the participants agreed must be taken into account to make the RCH programme effective. The following outlines an expanded reproductive health package.

- . Safe child bearing, with access to appropriate health services.
- . Care of gynaecological disorders.







- . Access to safe and affordable abortion services.
- . Capability to reproduce (infertility).
- . A safe sex life without fear of disease, coercion and unwanted pregnancy.
- . Safe, effective, affordable and acceptable methods of family planning, with informed choice being emphasized.
- . Special attention to adolescents, girls and boys.
- . Mental health.
- . Domestic violence issues.
- . Occupational health, including housework.

There must be efforts made to raise awareness within the community about these, including how to spot symptoms and where care for them may be sought. Legal rights and wrongs must be clear regarding age of marriage, abortions, etc. The right to informed choice must govern all such efforts of education. Special efforts need to be made to bring women into the circle of health care, given their poor access. Service providers must be aware of cultural constraints on adolescents seeking care for gynaecological problems.

### **Recommendations regarding Target Free Approach**

The following sections deal with recommendations that were suggested by the participants for improving health care in the target--free approach as outlined in the manual. There was repeated discussion on what exactly 'removing targets' entails. The view was expressed that as far as providing clear unambiguous guidelines to the care providers at various levels of service was concerned, there had to be indicators of some sort. They must be used to both motivate the health workers, as well as evaluate their performance. The meeting was informed that Maharashtra was trying to put in 'target free targets' by making up their own manual. It stressed self--generated targets, set up by community representatives and health workers together. This would take into account their specific health needs in their social and cultural contexts, instead of being imposed on them in a top down fashion. Sterilisation targets have been put at the end of the list and current evaluation is being done comparative to last year, without any demand on meeting those levels.

It was also pointed out that health workers who have been trained for the past four decades in chasing sterilisation targets were not going to be able to make a fast transition to not having them. So what should the new targets be, if any? What roles should various public health workers play in the new system? How should they be evaluated? There were detailed discussions on these questions and the following sections present them, along with specific recommendations.

### **The human workforce**

The ANM turned out to be the fulcrum around whom revolved all the changes in human resource management that were required if the system was to serve the purpose of broad based provision of reproductive health care. Research presented showed a dismal state of affairs as far as the ANM's position in the system, both state and social, was concerned.





It was found that the TFA assumed that the ANMs are independent and confident planners. However, on close examination it was found that most ANMs operate under no professional supervision. They are usually women from disadvantaged classes. This makes them vulnerable in both ways, the sexual and the social. They have no bargaining powers in either contexts in times of pressure. Most of the times they are stationed in villages away from their homes and cannot take advantage of family support in times of need, nor can they count on social support from their environs. They do outreach programmes to identify care needs and travel extensively among surrounding villages. This raises the issue of their security and comfort. They also work with very poor infrastructure at the subcentre, while they are held responsible for its performance. ANMs typically take care of child and reproductive care work, and as such are seen more as dai's than as trained medical personnel. On the other hand their men co-workers as the Multi-Purpose Workers (MPWs), tend to be seen as 'doctors', even though they do the same amount of curative care as the ANMs. They are mostly malaria workers, collect TB slides, chlorinate wells, and so on. So the ANM is marginalised both socially and professionally, while having the maximum responsibility on her shoulders in terms of running the subcentre, in which the MPWs have no share.

It is also on the ANM's shoulder that the entire grass-root implementation of family planning policy has rested for all these years. Finally, it is her performance in pushing contraceptives and doing immunisations that reflects in the targets being monitored. Now that these targets are being removed it is imperative that she be given a clear job description. Some of the suggestion made for improving the ANM's role are as follows :

- . The role of the ANM has to be substantially strengthened. She must be given clear responsibilities in terms of the care she is to provide. The strongest consensus on this point was that she should not be asked to do 'family planning' work, but should simply take care of family health in general, more specifically women's reproductive system morbidities and child care. In fact, she can maintain family registers of health histories. They can be used both as means of monitoring her work, and also to draw a complete health picture of the rural families. At this point in time, no such data is available.
- . In order that she is able to carry out these duties efficiently she must be backed up by a more curative care oriented subcentre than what exists now. She must be trained to look for symptoms of gynaecological morbidities and in cases where she cannot treat them, be able to refer them to PHCs with the confidence that they will be treated promptly and properly. This is a vital link in making her position within the community strong. People must have confidence that she is indeed the link between them and quality care at larger centres.
- . She must have team support from the MPWs. Outreach work should be done more by the now defunct Community Health Volunteers(CHVs), rather than having the ANM traveling over large geographical areas. The CHV scheme should be re--examined and re--instated. While outreach work is necessary for identifying care needs, this work is best suited to the CHVs since they can do it for their own respective villages. It gives them the advantage of being physically and socially accessible within the community. It also makes them accountable to the community. The ANM cannot, and should not be asked to, do this work for a large number of villages.
- . The ANM must be motivated by prospects of promotion. If it is found that she cannot be promoted to higher posts within the medical care set up, she should be considered for





managerial positions. Stagnating her in the same position for years will breed indifference to the work she must do, along with discontent.

. In the new TFA, she should be encouraged to interact with the community to find priority areas of health care needs and set up targets to improve the health picture in that locality. For all this, she needs training in leadership, communication, and personality development.

. If the ANM is to be the first and most accessible link between the people and the state health system, she must be given the necessary tools, both medical and human, to sustain that position effectively. Along with responsibilities, the ANM's decision-making power has to be substantially strengthened.

Among other suggestions for improving the efficiency of the health workers, there was a lot of emphasis placed on re-training. It was felt that from the ANM/MPW upward, including the Medical Officers (MOs), the District Health Officers (DHOs), and all the managerial staff at the PHCs and RHs, needed gender sensitivity training. It is not correct to assume that all illnesses, even those outside of the reproductive system of the woman, affect men and women similarly. As pointed out in an earlier section, the woman is very constrained in socio-economic ways as men are not and needs appropriate consideration when providing care. The health workers must be made aware of it and given training to deal with the situations.

MOs and DHOs should be given periodic re-training in diagnostic skills using medical college hospitals. RHs should have a regular woman gynaecologist on a visiting basis. It was also felt that there should be an effort made to attract women to take up jobs as MO/DHOs. Incentives such as seat reservation in local schools for their children could be offered. In general, the presence of professional women in the state medical care system should be greatly enhanced.

Another area of discussion was the inclusion of the private sector into the health system. Although it was agreed that this was a good idea, there was apprehension expressed that this would be done in haste, without doing a thorough study of the quality and range of care that they provide and how it should be regulated in a collaboration with the state. Such a study is absolutely necessary. Professional bodies with consumer groups and the government should evolve standards and accreditation systems before any effort is made to integrate the private sector in the RCH programme.

### **Infrastructure, quality of care, and evaluation**

The ramshackle state of the public health infrastructure was reflected in a study of drug supply in Satara district. Various PHCs and RHs were surveyed. It was found that no one single drug was available in the PHCs throughout the year. Only about 3 percent of the total supply was available on a regular basis, and 55 percent were effectively not available. The situation in the RHs was not noticeably better, 38 percent of the drugs being available only very irregularly. The total supply to the public sector was about 56 lakhs, while an estimate of the use by private sector was about 21 crores, which is closer to the estimate of drug requirement in this area for an extrapolated morbidity load. This shows very strongly that





there is no facility for curative care, even for common ailments, within the public health system. The entire budget and supply is geared for immunisations and family planning/contraception activities. This trend continues in the TFA manual. The manual mentions only some 7-8 drugs to be supplied to PHCs, while the drug kit is supposed to have some 80-90 drugs. There seems to be complete confusion on this issue. As a national health policy this goes against common sense. Poor people in rural areas must have basic curative care access to their PHCs, not just for contraception and family planning.

While drug supply is one aspect of the issue of access, other severe problems regarding infrastructure were pointed out by participants. All these directly affect the quality of care issue. Physical locations of PHCs serving a given geographical area was of great importance. If people have to spend an entire day traveling back and forth to the PHC, the incentive for doing so is going to be very low, and quacks and other unqualified 'doctors' will then be used. Reliable state transport services which are extremely necessary as a back-up to utilisation of public health facilities are also not available in remote rural and tribal areas. If only 15 people from each village go to the PHC every day, the existing state bus service will not be sufficient. Universal access to basic health care must be the guiding principle in planning these resources, backed up with development infrastructure.

It was felt that this bad planning for infrastructure also reflects the poor state of data collection for both need assessment, and the quality of care being provided. There is no data on the former, since public health has been synonymous with family planning and contraception. General health care has been dealt with on 'campaign' basis once in a while for mostly highly communicable diseases such as tuberculosis, leprosy, etc. However, even care for these is not available on a regular basis, much less for other common ailments. The evaluation of the quality of care is again family planning oriented, with health workers being asked to fill out forms with this focus. Unfortunately this policy continues even in the new manual of the TFA.

With this background, the participants came up with strong recommendations for improving the infrastructure, with the help of relevant data collection based on rational indicators of health, that would then help the care providers at the PHCs and RHs improve their quality of care.

. Since all infrastructural changes can be made only on the basis of data on need assessments, this should be started immediately. What data should be collected from which health functionary and how should it be used? Collection of sensitive and intimate information about people's lives or about NGOs/social action groups raises ethical and political concerns since this data is centralised, globalised, and used to draw conclusions for the purposes of policy making that then directly affect the services being provided at grass root level. There was also consensus among the participants that there was too much data being collected. This issue raised concern among participants because excessive data collection would create resentment among people as their time and energy would be unnecessarily consumed. Even the ANM was asked to provide so much data that there was little time left for her to actually do health care work. Since it was agreed that the basic function of the PHC was to provide basic curative care, it was felt that maintaining family health registers would give far more information about health needs in a community than only keeping





records of contraception and other family planning indicators. This data can then be pooled together at the district levels for planning finances, drug supplies, training requirements for personnel and infrastructural changes. This means that such data needs to be processed fast. Decentralising this process will help tremendously in a fast response to the health needs of a community. Updating of this kind should be a continuous process, instead of being done once in several years.

- . There needs to be rationalisation of both the drug supply to PHCs, and their locations. Locations should be governed by time taken by the community being served to access the PHC, and not by the political clout of a particular village. The drug supply should be based on the health needs of each locality. Curative care for common ailments should be available on a regular basis, rather than in fits and starts.

- . What indicators should be used to survey both the health picture of a community, and the performance of its care provider? The most strong recommendation was that these indicators should be evolved with the consensus of the community. Mahila Mandals, panchayats and other bodies within the villages should be involved in the process. They should be asked both about their care needs, as well as how they are being served in their alleviation. User reports should be collected on a regular basis. Removing population control targets should not leave the health providers with the feeling that there is no more work to be done. They should be motivated to set up their own targets with the help of the community and be evaluated on that basis.

- . Women's reproductive health indicators should be evolved keeping in mind, as outlined in the section on Women's Health, that they have morbidities other than those related to child-bearing, and that care seeking for these is a strong function of their social and economic status. If regular data is collected for all these even at the level of family registers, it would be possible to draw correlated pictures for health needs of women in different socio-economic and age strata. Again, their access should also be taken into consideration by updating outreach programmes and providing them with spaces in which to discuss these issues without feeling either pressured or threatened.

- . All these tie directly back into the issue of training of health care providers. It should be made gender sensitive and this is a point on which there should be regular evaluation, especially from the user's point of view.

- . The whole system of infrastructure, along with evaluation, and assessments of health needs should have in place some measures to assess and apportion responsibilities in case of failure. That something does not work should not be reduced to a piece of paper which is nobody's responsibility. There should be clear guidelines for taking care of such situations promptly.

It was felt at various stages of the discussion that provision for trained and motivated personnel who are actively involved in the health issues of the community is the minimum necessity of the infrastructure. It is not a good idea to ask them to fill out forms for indicators that have been prepared with the national agenda of family planning in mind. No single community can be forced to tow a national policy to the exclusion of their other, most often, more immediate and demanding health needs. Empowerment of the communities to have a say in the health services they require is of primary importance. For this, a revamping of data collection, its decentralisation, fast processing, and subsequent planning of resources both material and human is now a pressing need.





## Concluding Remarks

The target free approach came in for a great deal of detailed scrutiny in this meeting. Both its policy level foundations and its implemetational effectiveness were thoroughly examined. The main broad issues on which there was consensus are the following.

- Public health workers must be used to provide basic curative care which is client oriented. They must not be used to chase population control targets, or family planning agendas of various sorts.
- The reproductive and child health package should be part of a general basic health care plan, whose driving aim should be to have a healthy population, not a 'family planned' population that does not even have access to basic curative care for common ailments. The operative word in health policy should be health, family planning being a part of it, instead of being the other way round.
- Women's health must be taken out of the family planning bracket and put firmly into a more comprehensive health plan. Their needs must be assessed in terms of their socio-economic situation and care delivery must be appropriately tailored.
- Decentralising the need assessment system will be so much more logical if such a health policy was put in place. This can then be used to make the delivery of health care far more rational in terms of both; what people need and how efficiently they can access it.



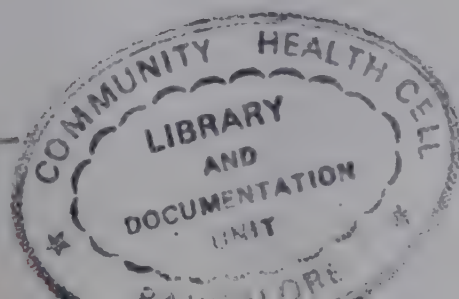


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